| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555398 | A. Building<br>B. Wing | 05/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hayward Post Acute | 25919 Gading Road<br>Hayward, CA 94544 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and revise a comprehensive person-centered care plan for Resident 1 when their nasogastric tube (NGT is a soft tube inserted through the nose, throat and into the stomach to provide nutrition, hydration, and medications when a person can't eat by mouth ) dislodged three times within a 17-day period. This failure placed Resident 1 at risk for aspiration, interruption of nutrition and hydration, missing medication doses, and repeated exposures to X-rays.During a record review of Resident 1's admission Record (AR) printed on 5/13/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including stroke (brain suddenly stops getting enough blood) and dysphagia (have trouble swallowing).A review of Resident 1's Minimum Data Set (MDS, an assessment tool to direct residents' care) dated 12/30/25 indicated Resident 1 had a Brief Interview for Mental Status (BIMS, a scoring system to identify memory, orientation, and judgment status of residents) score of 15 out of 15. A BIMS score of 15 indicated that the resident is cognitively intact.A review of Resident 1's care plan initiated on 12/27/25 indicated Resident 1 had an NGT in place to meet nutritional needs, however, no interventions were identified to prevent the NGT from becoming dislodged. During a review of the Change in Condition Evaluation (CICE) dated 12/28/25, the CICE indicated when the licensed nurse went to the room to check the resident, nurse found the NGT was pulled out. The CICE indicated Resident 1 was alert and oriented times two (a person is awake, knows their own name, and knows where they are) and able to obey simple commands. The CICE also indicated that the physician ordered to reinsert the NGT and an X-ray to confirm proper tube placement.A review of the care plan initiated on 12/28/25 indicated an intervention to closely monitor and secure placement of NGT every shift. however, there is no evidence for monitoring parameters or an assessment of the factors contributing to the NGT dislodgement. During a review of CICE dated 12/30/25 indicated Resident 1 had pulled out his NGT. The CICE indicated the physician ordered NGT reinsertion and a follow-up X-ray for verifying placement. However, the care plan was not revised to identify the cause of the repeated NGT dislodgements or to implement person-centered interventions to prevent further NGT dislodgement. During a review of CICE dated 1/11/26, the CICE indicated Resident 1's NGT was pulled out for the third time. The CICE indicated that Resident 1 was confused at the time of the event.A review of Resident 1's care plan dated 1/11/26 showed no evidence that nursing staff reassessed Resident 1's behavior, evaluated the cause of repeated NGT dislodgements, or implemented a person-centered intervention(s) to prevent further episodes. During an interview on 5/14/26 at 9:24 a.m., RN 1stated that the resident-centered comprehensive care plan should be developed within seven days of admission and revised after each incident to reflect residents' current situation.During an interview on 5/14/26 at 10:00 A.M., the Director of Nursing (DON) stated that the care plan should be measurable and resident centered.A review of the facility's Policy and Procedures (P&P) titled Care Plan Comprehensive, effective date 8/25/21, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that one of seven sampled residents (Resident 2) received the necessary care and services according to their clinical needs related to diabetes (a chronic disease in which the body has elevated blood sugar, also call blood glucose) monitoring, ileostomy (surgical procedure that creates an opening in the abdominal wall, bring the end of the small intestines to the surface to allow waste to exit the body directly into external pouch call ileostomy bag, bypassing the colon and rectum.) care, medication management, and indwelling urinary catheter (also called Foley catheter, a thin, flexible tube inserted into the bladder and left in place to continuously drain urine) care when1. Resident 2 was receiving insulin (a medication that lowers blood glucose), yet the facility did not document their blood glucose levels.2. Resident 2 received laxative (medication or substance to lose stools and increase bowel movements) while having large, watery stools, and at the same time continued to receive medication for diarrhea.3. Resident 2 had an indwelling Foley catheter (F/C),but the facility failed to provide catheter care, monitoring, and documenting urine output and urine characteristics.This failure resulted in inadequate clinical oversight and placed Resident 2 at risk for unrecognized changes in condition, complications related to diabetes, dehydration, and infection.Based on interviews and record reviews, the facility failed to ensure that one of seven sampled residents (Resident 2) received the necessary care and services according to their clinical needs related to diabetes (a chronic disease in which the body has elevated blood sugar, also call blood glucose) monitoring, ileostomy (surgical procedure that creates an opening in the abdominal wall, bring the end of the small intestines to the surface to allow waste to exit the body directly into external pouch call ileostomy bag, bypassing the colon and rectum.) care, medication management, and indwelling urinary catheter (also call Foley catheter, a thin, flexible tube inserted into the bladder and left in place to continuously drain urine) care when1. Resident 2 was receiving insulin (a medication that lowers blood glucose), yet the facility did not document their blood glucose levels.2. Resident 2 received laxative (medication or substance to lose stools and increase bowel movements) while having large, watery stools, and at the same time continued to receive medication for diarrhea.3. Resident 2 had an indwelling Foley catheter (F/C), the facility failed to provide catheter care, monitoring, and documenting urine output and urine characteristics.This failure resulted in inadequate clinical oversight and placed Resident 2 at risk for unrecognized changes in condition, complications related to diabetes, dehydration, and infection.Findings:During an interview on 5/14/26 at 8:08 a.m., the complainant stated that Resident 2's Responsible Party (RP) reported Resident 2's ileostomy bag was consistently full and leaked onto Resident 2's clothing during their stay in the facility. During a review of Resident 2's admission Record (AR) date 5/14/26, the AR indicated that Resident 2 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, long-term use of insulin, urine retention, and ileostomy status.During a review of Resident 2's Minimum Date Set (MDS, an assessment tool to direct resident care) dated 1/26/26, the MDS indicated that Resident 2 had an indwelling catheter, an ileostomy, and was receiving insulin injections as well as oral medication to decrease blood glucose levels.During a review of Resident 2's January 2026 Medication Administration Record (MAR), the MAR indicated that Resident 2 received insulin twice a day on 1/23, 1/24, 1/25, and once on 1/26. The MAR also indicated that blood glucose was monitored before meals and at bedtime; however, the blood glucose results were not documented for the care team to review trends or identify abnormal values. (blood glucose was documented once on 1/25/25 at 5:55 am).During a review of Resident 2's January 2026 MAR, the MAR indicated that Resident 2 was receiving MiraLax (an over-the-counter laxative used to treat constipation) powder, 17 grams by mouth daily on 1/23, 1/24, 1/25 and 1/26. The instructions for MiraLax indicated hold for loose stool. The MAR also indicated Resident 2 was receiving Loperamide (a medication used to treat diarrhea) 2 milligram (mg), one tablet by mouth, on 1/22, (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1/23, 1/24, 1/25, and 1/26 for diarrhea.A review of Resident 2's Documentation Survey Report (DSR) of January 2026, the DSR indicated Resident 2 had large, watery stools on 1/23 at 5:33 a.m., 2:59 p.m., and 8:43 p.m., and 1/25 at 6:59 a.m.A review of Resident 2's Change in Condition Evaluation (CICE) dated 1/26/26 at 8:52 p.m. indicated Resident 2 experienced a change in mental status, a drop in blood pressure to 60/45, and was ultimately transferred to the emergency room for evaluation.During a record review and interview on 5/14/26 at 10:21 a.m. with Director of Nursing (DON), there was no evidence that F/C care or monitoring had been provided, and no care plan was in place for the F/C or ileostomy. DON stated that these are basic nursing measures that should be implemented and care-planned upon admission. During an interview on 5/18/26 at 10:07a.m., Licensed Vocational Nurse (LVN) 1 stated nursing staff should check and document blood glucose levels for residents with diabetics to monitor for hyperglycemic (there is too much glucose in the blood) and hypoglycemic (glucose level in the blood drops too low). LVN 1 further stated that nursing staff should monitor bowel movement (BM)s for residents with ileostomy to identify signs and symptoms of constipation, diarrhea, or bowel obstruction, and that urinary output should be monitored and documented to detect early signs and symptoms of catheter blockage or urinary tract infection.During an interview on 5/18/26 at 10:28 am, DON stated Certified Nursing Assistance (CNA)s are expected to report to the charge nurse when residents have diarrhea. DON stated charge nurse should monitor the characteristics of residents' urine and BMs especially for those with a F/C or an ileostomy. DON further stated that it is standard nursing practice to monitor and document BG levels, urine output, and BM output. DON stated the nurses are expected to contact the physician to clarify whether Resident 2 should receive medication for both diarrhea and constipation at the same time. During a review of facility's Policy and Procedures (P&P) titled Nursing Care of the Older Adult with Diabetes Mellitus, revision date 4/2026, subtitled Blood Glucose Monitoring, No. 3. For the residents receiving insulin whose BG is well controlled: a. monitor glucose levels twice a day if on insulin.A review of the facility's P&P titled Providing Catheter Care, no revision date, indicated during catheter care, the urine characteristics, color, clarity, odor and volume should be documented. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate monitoring and implement appropriate interventions for Resident 1 when Resident 1's nasogastric tube (NGT is a soft tube inserted through the nose, throat and into the stomach to provide nutrition, hydration, and medications when a person can't eat by mouth) dislodged three times within a 17-day period. This failure placed Resident 1 at risk for aspiration, interruption of nutrition and hydration, missing medication doses, and repeated exposures to X-rays.During a record review of Resident 1's admission Record (AR) printed on 5/13/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including stroke (brain suddenly stops getting enough blood) and dysphagia (difficulty swallowing).During a review of Resident 1's Minimum Data Set (MDS, an assessment tool to direct residents' care) dated 12/30/26 indicated Resident 1 had a Brief Interview for Mental Status (BIMS, a scoring system to identify memory, orientation, and judgment status of residents) score of 15 out of 15. A BIMS score of 15 indicated that the resident is cognitively intact.A review of Resident 1's care plan initiated on 12/27/25 indicated Resident 1 had an NGT in place to meet nutritional needs, however, no interventions were identified to prevent the NGT from becoming dislodged. During a review of the Change in Condition Evaluation (CICE) dated 12/28/25, the CICE indicated when the licensed nurse went to the room to check the resident and found the NGT was pulled out. However, the document does not specify who removed the tube, or how it happened. The CICE indicated Resident 1 was alert, oriented times two (a person is awake, knows their own name, and knows where they are) and able to obey simple commands. The CICE also indicated that the physician ordered to reinsert the NGT and an X-ray to confirm proper tube placement.A review of the care plan initiated on 12/28/26 indicated an intervention to closely monitor and secure placement of NGT every shift. however, there is no evidence for monitoring parameters or an assessment of the factors contributing to the NGT dislodgement.During a review of CICE dated 12/30/25 indicated Resident 1 had pulled out his NGT. The CICE indicated the physician ordered NGT reinsertion and a follow-up X-ray for verifying placement. However, the care plan was not revised to identify the cause of the repeated NGT dislodgements. There was also no evidence that the interdisciplinary team (IDT) implemented any intervention or increased supervision to prevent further NGT dislodgment.During a review of CICE dated 1/11/26, the CICE indicated Resident 1's NGT was pulled out for the third time. The CICE indicated that Resident 1 was confused at the time of the event.A review of Resident 1's care plan initiated on 1/11/26 showed no evidence that nursing staff or ITD reassessed Resident 1's behavior, evaluated the cause of repeated NGT dislodgements, or implemented a person-centered intervention(s) to prevent further episodes. A review of Resident 1's CICE dated1/28/26 indicated Resident 1 developed a productive cough and experienced a decrease in oxygen saturation (O2 sat, a measurement of how much oxygen the blood is carrying as a percentage, normal level is 95-100 percent, below 95 indicates a person is not getting enough O2) to 89 percent, resulting in transfer to the hospital.During an interview on 5/14/26 at 10:00 A.M., the Director of Nursing (DON) stated that residents with NGTs are at high risk for dislodging and aspiration and should be monitored closely to prevent dislodgement. DON stated that staff had been checking Resident 1 hourly, however, the DON was unable to provide document supporting that hourly monitoring occurred.During a review of the facility's Policy and Procedures (P&P) titled NG tube/tube feeding/ re insertion, effective date 6/27/22, the P&P did not include guidance on monitoring NGT. |